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SUPPURATIVE METRITIS; ULCERATIVE ENDOMETRITIS AND METRITIS; DOUBLE PYOSALPINX AND AN OVARIAN ABSCESS; EMBOLIC PNEUMONIA FOLLOWING LABOR; HYSTERECTOMY; RECOVERY.

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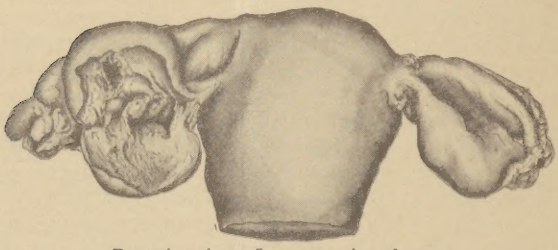
THE patient whose case is herewith reported was admitted to the Philadelphia Hospital a month after her delivery. She gave a history of having been ill and feverish since the childbirth. She had been taken from a squalid hovel, where she had received no care. At first glance it seemed apparent that she had not long to live. The temperature was high, the pulse rapid and feeble, the respirations hurried and shallow, the abdomen tympanitic and exquisitely sensitive, and there was profound prostration. On vaginal examination the uterus was found large, boggy, firmly fixed, with sensitive masses behind and on each side. Over a considerable area of the right lung, especially toward the apex, there was diminished resonance, together with numerous fine râles. The abdomen was opened as soon as practicable. At the fundus of the womb a perforation was made into the cavity by pressing lightly upon it with the finger-tip. The ulcerative process had destroyed the muscular wall to the peritoneal covering. On both sides of the uterus, about an inch below the insertion of the tubes, were

large abscesses in the uterine wall. Both tubes were distended with pus, and there was a large ovarian abscess on one side. The broad ligaments were much thickened, being quite an inch thick at their base. On this

FIG. 1.

Anterior view: Perforation at fundus; abscess opened, to the left; abscess unopened, to the right; double pyosalpinx.

FIG. 2.



Posterior view: Large ovarian abscess.

account the removal of the womb and the control of the hemorrhage was extremely difficult. The patient reacted well after the operation, and made a good recovery, although her convalescence was somewhat delayed by an abdominal fistula that finally, however, closed spontaneously.

It would be scarcely possible to find a more unfavor-

able case of puerperal sepsis for radical operative treatment. The successful issue is encouraging as an evidence that one need not necessarily despair, even in advanced cases and in involvement of important structures, necessitating the removal of all the genitalia above the vagina or above the cervix. A cure, however, by surgical treatment, especially if hysterectomy is required, is and must remain exceptional. The recent literature upon this subject, unless carefully studied in the light of personal experience, is misleading. Hysterectomy has been done successfully for puerperal sepsis when it was not at all necessary. I saw last winter two perfectly healthy wombs removed for fever after childbirth. The unfortunate women, unnecessarily mutilated, would have probably recovered much more rapidly, and certainly much more safely, under intra-uterine disinfection and stimulus and support. Several of the reported cases are also open to this criticism. On the other hand, a number of fatal hysterectomies for puerperal sepsis have not been reported. Eliminating the unnecessary operations, and, were it possible, collecting all those that have been unsuccessful, it would appear that hysterectomy for puerperal sepsis has a frightfully high mortality. But even if but one case out of a hundred is saved, the operation deserves credit, for without it, in a case really requiring the removal of an infected womb, the patient must inevitably die.

An important problem in this connection is the decision whether in a given case operative treatment promises something for the patient or is surely foredoomed to failure; and, again, whether operative treatment is really required. These questions cannot always be answered till the abdominal cavity is explored after incision of its walls. But the following rule governs my own action at present:

If there is no evidence of extension of inflammation beyond the womb itself, do not operate.

This at once excludes a large number of cases: diphtheric endometritis; suppurative metritis, in which the abscess is nearer the uterine than the peritoneal cavity; catarrhal and suppurative endometritis, in which the tubes are not involved, to the extent, at least, of closure and collection in them of pus; phlebitis; sapremia. In diphtheric endometritis the removal of the womb has in my experience had no influence on the course of the disease. I have, indeed, not yet seen such a case recover under any treatment. If the abscess in suppurative metritis is near the uterine cavity, it will probably discharge into the birth-canal, as I have seen it do. If, on the other hand, it extends toward the peritoneal cavity, exudate is poured out, the womb is fixed, and an indication is afforded for operation. The other varieties of sepsis enumerated are obviously not amenable to treatment by abdominal section. On the other hand, the septic conditions that have demanded operative treatment after labor are, in my experience, purulent peritonitis, localized or diffused; suppurative metritis; ulcerative metritis, threatening and actually causing perforation; pyosalpinx and ovarian abscess; suppuration of the infiltrated connective tissue in the floor of the pelvis and at the base of the broad ligaments. This last condition calls not for abdominal section in the ordinary sense, but for an extra-peritoneal incision above Poupart's ligament or through the vaginal vault.